COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

June 13, 2005

FOOD STAMP CERTIFICATION MANUAL – VOLUME V

TRANSMITTAL #63

This transmittal contains changes to the policy for the Food Stamp Program put forth by the 2005 General Assembly. These changes affect households eligible for transitional benefits and individuals disqualified for felony drug convictions beginning July 1, 2005.

Under current rules, nearly all households whose Temporary Assistance for Needy Families (TANF) cases close for reasons other than for noncompliance are eligible to receive transitional benefits. This transmittal includes an additional reason for households who are ineligible to receive transitional benefits. Households will not be eligible for transitional benefits if the TANF case is closed because all the eligible children are out of the home as a result of a protective services investigation.

This transmittal changes household composition rules so that individuals who have felony convictions for possession or use of controlled substances will no longer be disqualified from participating in the Food Stamp Program in Virginia as long as they comply with any court-imposed obligations, such as periodic drug testing. This change means that conviction of a felony for distribution of controlled substances will continue to be disqualified from receiving food stamp benefits.

This transmittal also contains other revisions and clarifications that affect the Food Stamp Program, including the list of localities whose residents will be exempt from time-limited benefits of the work requirement. Information about the methodology for determining which localities are exempt was previously announced in Broadcast # 3223, issued June 2, 2005.

The provisions of the transmittal are effective July 1, 2005 for eligibility determinations for July 1, 2005 or later.

The transmittal changes and guidance for maintenance of the certification manual follow. The certification manual and this transmittal are available on the Intranet at http://www.localagency.dss.state.va.us/divisions/bp/fs/manual.cgi and on the Internet at http://www.dss.state.va.us/benefit/fs_manual.html.

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Remove Page(s)	Insert Page(s)	Significant Changes
Part III Pages 5-6	Part III Pages 5-6	Verification of disability to establish separate household composition for elderly, disabled persons was clarified to include a statement from licensed medical providers instead of a physician. Verification statements may be provided by a physician, nurse practitioner or midwife, or other medical staff. This identification is addressed throughout this manual.
Part VI Pages 7-10	Part VI Pages 7-10	The list of persons who are ineligible to participate in the Food Stamp Program was changed to show that persons who have felony convictions for possession or use of controlled substances will be eligible for benefits if they participate in testing, treatment or any other obligations the court assigns. The client's statement will be used for this determination of compliance. Persons convicted of felonies that are for the distribution of controlled substances will still be ineligible. This section was also changed to remove a reference to Workfare.
Part VIII Pages 3-4	Part VIII Pages 3-4	Verification of disability to qualify for a work registration exemption was clarified to include a statement from a licensed medical provider instead of a physician.
Part XII Pages i-ii	Part XII Pages i-ii	The Table of Contents was revised to show page numbering changes.
Pages 15-16	Pages 15-16	The section on handling disqualified or ineligible persons was revised to delete a reference to Workfare.

Remove Page(s)	Insert Page(s)	Significant Changes
Pages 23-24	Pages 23-24	The Transitional Benefits section was changed to list another instance when households would be excluded from receiving transitional benefits. Households will not be eligible if the TANF case closes because the eligible children are removed from the home because of a protective services investigation.
Part XIV Pages 1-2	Part XIV Pages 1-2	In addition to providing the Change Report form to households at application and when households report a change in the size of the unit, the agency must provide the Change Report form when the agency makes a change that affects the household size.
Part XV Appendix 1 Page 1	Part XV Appendix 1 Page 1	Localities exempted from the work requirement because of their unemployment rates or being classified as a Labor Surplus Area were listed.
Part XXIV Pages i-ii	Part XXIV Pages i-ii	The Table of Contents was revised to update the version numbers of forms.
Pages 1-18	Pages 1-18	The application was revised to regroup questions involving resources based on programs' needs.
Pages 20-21	Pages 20-21	The Eligibility Review Part A was revised to reformat some of the entries.
Pages 50-51	Pages 50-51	The advance notice was revised to remove lump sum information from the TANF section and information about FAMIS Plus was added to the Medicaid section.
Pages 63-66	Pages 63-66	The Request for Assistance was revised to rename refugee assistance benefit programs.

Remove Page(s)	Insert Page(s)	Significant Changes
Pages 75-77	Pages 75-77	The internal action form was revised to allow the authorized representative to receive an EBT vault card and to include the address of the cardholder.
Pages 92-93	Pages 92-93	The administrative disqualification hearing referral form was reformatted.

S. Duke Storen
Director
Division of Benefit Programs

Attachment

If the household fails to provide the necessary information that would allow the verification of an SSN, the household member for whom the number is unverified is ineligible.

If a household must provide information or documentation to the local agency or the SSA, the household must complete the action before the next recertification or show good cause why it was unable to do so.

If a household claims it cannot complete required actions for reasons beyond its control, the EW must verify the household's inability to cooperate. For example, a household may claim it cannot verify a name change because fire destroyed official records. The EW must verify this claim to the point he/she is satisfied the claim is accurate, i.e., documentation of the name change no longer exists. In these cases an SSN match cannot be accomplished since SSA records cannot be corrected without the missing documentation. If the EW verifies that the household is unable to provide the information needed to verify the SSN, the household member will remain eligible. The case file must adequately document the household's inability to provide the information.

Conversely, if the EW is unable to substantiate the household's claim that it cannot provide the information, the household member will be ineligible.

Appendix I to this chapter contains suggested language for a form that the EW may give to clients who must provide SSA with information or documentation to complete the verification process.

k. Disability (7 CFR 273.2(f)(1)(viii))

Whether the stricter or more relaxed definition of disability is evaluated, disability status of individual household members must be established. If a household fails to verify disability when necessary, the individual in question is not considered disabled.

Work Registration, Student Identification, Work Requirement
A statement from a licensed medical provider is sufficient for the less restrictive standards for these policy areas. Receipt of temporary or permanent disability payments may also be used.

Separate Household Status for Elderly, Disabled Persons
For elderly, disabled persons who are unable to purchase and prepare meals separately, the agency must first determine the disability and then establish that these persons are unable to purchase and prepare meals because of the disability. The Social Security Administration's list of disability conditions may be used for this evaluation.

If it is obvious that the individual could not purchase and prepare meals because of the disability, the agency must consider the individual disabled even if the disability is not specifically mentioned on the SSA list. If the disability is not obvious, the EW must verify the disability by a statement from a **licensed medical provider** or licensed or certified psychologist, along with a statement that, in the doctor's opinion, the disability prevents the individual from purchasing and preparing meals.

Disabled for Determining Eligibility for Group Homes, Medical Expenses, Unlimited Shelter Expenses, Net Income Standards, 24-month Certification Periods, Resource Eligibility, Immigration Eligibility, Exemption from Interim Reporting
Verification of this evaluation of disability, as noted in Definitions, will usually be determined by receipt of or approval for certain income sources or benefits. For example, approval for or receipt of a disability check from the SSA, including SSI, verifies disability.

1. Child Support Payments

A household member's legal obligation to pay child support, the obligated amount of support to be paid, and the amount of child support actually paid must be verified in order to allow a deduction.

Documents which may be used to verify the household's legal obligation to pay child support and the obligated amount include a court or administrative order, or a legally enforceable separation agreement. The actual payment of support may be verified through such methods as cancelled checks, withholding statements from wages or unemployment compensation, statements from custodial parents about direct payments or payments made to third parties, or payment records of the Division of Child Support Enforcement. The same document accepted as verification of the legal obligation to pay child support may not also be used as the verification of the amount of child support actually paid monthly.

No. of boarders being considered as a separate household	Minimum monthly payment (This is two-thirds of the maximum coupon allotment, rounded down to the nearest whole dollar amount, for each household size indicated.)
1	$ 99
2	182
3	262
4	332
5	394
6	474
7	524
8	598

3) A reasonable monthly payment is equal to or will exceed the following amounts if the boarder takes more than two meals per day in the home.

No. of boarders being considered as a separate household	Minimum monthly payment (This is the maximum coupon allotment for each household size indicated.)
1	$149
2	274
3	393
4	499
5	592
6	711
7	786
8	898

If a single board payment is made for more than one boarder, all boarders for whom the payment is made are to be considered as a single household.

Example

A mother and daughter are boarding with another household. The mother pays board to the landlord for herself and her daughter. The mother and daughter are considered as one household if their board payment is equal to or greater than the required minimum monthly payment.

In instances where an individual is furnished only meals (lodging is not provided), the individual is considered a member of the household where most of the meals are taken, not as a boarder.

If the status is questionable, boarder status may be verified by obtaining a signed statement from the boarder and the person to whom the board is paid, attesting to the arrangement and the compensation provided.

C. NONHOUSEHOLD MEMBERS (7 CFR 273.1(b))

1. The following individuals residing with the household will not be considered household members in determining eligibility or the benefit allotment.

   a. Roomers: Individuals to whom a household furnishes lodging, but not meals, for compensation.

   b. Boarders: Those who meet the boarder definition as given in Part VI.B.

   c. Live-in attendants: Individuals who reside with a household to provide medical, housekeeping, childcare, or other similar personal services. To "reside with the household" means that the individual takes a majority of his meals in the home. Dependents of a live-in attendant will be considered as members of the live-in attendant's household. A person cannot be a live-in attendant in his own home.

   d. Ineligible students: Students who are 18 years of age or older and enrolled at least half-time in an institution of higher education who fail to meet the special eligibility criteria set forth in Part VII.E.

   e. Other individuals who share living quarters with the household but who do not customarily purchase food and prepare meals with the household.

Example

The applicant household shares a house with another family to save on rent. The two groups do not purchase and prepare food together. The members of the other family are not members of the applicant's household.

   f. Children in foster care that the household has opted to exclude from the food stamp unit.

Roomers, live-in attendants and individuals who share living quarters may participate as separate households, if otherwise eligible. Ineligible students, boarders, and individuals in foster care cannot participate as separate households.

Nonhousehold member status will not be granted to roomers, boarders, live-in attendants, or other individuals who meet the relationship criteria of Part VI.A.1 of this manual, merely because of their roomer, boarder, or live-in attendant status.

2. The following individuals residing with the household will be excluded from the household when determining the household's size for the purposes of assigning a benefit level to the household or of comparing the household's monthly income with the income eligibility standards. The income and resources of these excluded members, however, will be considered available to the remaining household members in accordance with Part XII.E. These persons may not participate in the Food Stamp Program as separate households.

   a. Ineligible Aliens: Individuals who do not meet the citizenship requirement or hold eligible alien status (Part VII).

   b. SSN Disqualified: Individuals disqualified for failure to provide a Social Security Number (Part VII).

   c. Fraud Disqualified: Individuals found guilty of committing an intentional program violation against the Food Stamp Program by a court of law or an Administrative Disqualification Hearing (ADH), or individuals who signed waivers to an ADH (Part XVII).

   d. Individuals disqualified for noncompliance with employment program requirements (Part VIII).

   e. Individuals who are fleeing prosecution of felony offenses or imprisonment for felony convictions, or persons who are violating conditions of probation or parole. Individuals must have knowledge of an outstanding warrant in order to consider them "fleeing." Individuals must have an opportunity to document that they have satisfied the warrant.

   f. Individuals convicted in federal or state court of felony offenses that occurred after August 22, 1996, related to the distribution of a controlled substance.

   Individuals similarly convicted of offenses for possession or use of a controlled substance will not be disqualified if they are complying or have complied with periodic screenings, treatment programs, or other obligations assigned by the court. The client's statement will be used to document compliance with the assigned activities.

   g. Individuals who receive benefits for a three-month period and who subsequently fail to regain eligibility under the Work Requirement (Part XV).

D. HEAD OF HOUSEHOLD (7 CFR 273.1(d))

The head of the household is designated when applications are filed, whether at initial application, reapplication or recertification. The designation of the head will be made either by the household or by the local agency. Under certain circumstances as described in Part VI.D.3, the head will be defined as the principal wage earner. Whether designated by the household or by the agency, the head must be identified in the case file at the time of certification or household change.

Other than sanctions for violations described in Part VI.D.3, no special requirements are to be imposed on the household or its head. The agency may not, for example, require that the head appear at the certification office to apply for benefits rather than another responsible household member.

1. Household Designation

Whenever an application is filed, the household may identify on the application a household member to be the head. Households with parent-child combinations may also designate the head whenever there is a change to the household's composition. The person selected as the head must be included on the Notice of Action at the time of certification or household composition change.

The household may select as head a household member who is an adult parent of children living in the household, an adult who has parental control of a minor child living in the household, or any other adult member. For an adult parent to be selected, there must be at least one natural, step-, or adopted child of any age in the food stamp household unit with an adult parent. For an adult with parental control to be selected, there must be at least one child under 18 years of age who is supervised or otherwise dependent on an adult living in the food stamp household.

2. Agency Designation

If households fail to designate the head by the 30th day for new applications or reapplications or by the verification deadline for recertification applications, the local agency shall determine the head. The agency must also designate the head if the household's adult members do not agree with the selection made by the applicant.

The designation by the agency will remain in effect through the certification period or until the head leaves the household.

2) The household consists of a married couple and their two children, ages 2 and 4. Either parent is exempt on the basis of the children under 6. The other parent must be registered for work if not otherwise exempt.

3) The household consists of two sisters, each of whom has a child under 6. Each sister is exempt.

e. An attendant for an incapacitated person. The incapacitated person is not required to be a household member. Accept the client's statement unless the information given is questionable.

f. Applicants for and recipients of unemployment compensation in Virginia. Since persons who apply for unemployment compensation in Virginia (for Virginia benefits) are automatically registered for Food Stamp purposes no special registration is necessary with one exception. Persons on strike who have applied for, but are not receiving unemployment compensation are not registered for work by the VEC and, therefore, must be registered by the local agency. If the exemption claimed is questionable, the EW is responsible for verifying the exemption with the appropriate VEC Office. Persons who have applied for unemployment compensation in another state and are not yet receiving the benefit, however, are not automatically exempt from work registration. The EW must contact the state in which application was made to find out if the person was registered for work at the time of application for unemployment compensation. Persons who have filed an interstate claim in Virginia against the state they have recently left are also exempt.

g. Regular participants in a drug or alcoholic treatment and rehabilitation program. Accept the client's statement unless the information given is questionable.

h. A person who is employed for cash wages, in any amount, or self-employed and working a minimum of 30 hours per week. This shall include migrant and seasonal farm workers who are under contract or similar agreement with an employer or crew chief to begin employment within 30 days. In determining whether an applicant is working a minimum of 30 hours per week, fluctuating work hours may be averaged. Since this exemption is tied to a weekly figure, the period for averaging should also be tied to a weekly figure. The number of weeks to be averaged cannot exceed either the length of the certification period or the twelve-month work registration period. The average may be based on any number

of weeks less than either of these two periods which will allow a reasonable approximation of the number of hours worked per week. Accept the client's statement unless the information given is questionable.

i. Persons working less than 30 hours per week, but earning at least the equivalent of the federal minimum wage multiplied by 30 hours.

j. Persons who are obviously physically or mentally incapacitated. When disability is not obvious, proof of the disability may be established by the approval for or receipt of disability benefits. See Definitions. Also, approval for or receipt of benefits such as TANF, GR, Medicaid, or Workers Compensation based on a disability which has been verified by that program will be considered as proof of disability. Other individuals claiming a disability exemption must substantiate such disability by a medical statement **from a licensed medical provider** or licensed or certified psychologist or by approval for or receipt of benefits upon verification of same, such as an insurance company.

k. A student enrolled at least half-time in an institution of higher education who meets the special eligibility criteria of Part VII.E.

l. Other persons enrolled at least half-time in any recognized school or training program, including summer school.

NOTE: A placement by the Food Stamp Employment and Training Program does not exempt a person from work registration.

2. Frequency of Registration for Work (7 CFR 273.7(c))

Each person required to register shall do so at the time of application or reapplication, and every twelve months thereafter. New household members, added during the certification period, must be registered at recertification.

The EW must explain to the applicant the work registration requirements, an individual's rights and responsibilities, and the consequences of failure to comply with the registration process and work requirements.

PART XII SPECIAL INCOME DETERMINATIONS

PART XII SPECIAL INCOME DETERMINATIONS

1. For federal, state, or local public assistance programs, such as TANF or GR, failure to comply will be determined to exist after it has been established that policy exemptions and good cause provisions, if appropriate, have not been met. Failure to comply may also be evidenced by a court conviction for a fraud conviction or a finding through the ADH process.

   When TANF or GR benefits are decreased because of the household's failure to comply with that program's requirements, the food stamp allotment will be based on both the current amount of the TANF or GR check and the amount of the reduction or penalty. The penalty income must be counted as long as the reduced payment is received. If the PA case is closed, the penalty income must be counted in the food stamp calculation for a minimum of six months following the closure of the PA case or longer if the PA case remains under care.

   Example

   > The agency reduced a household's TANF grant from $291 to $241 per month. The reduction occurred because of the household's failure to comply with the immunization requirements needed by TANF program rules. The TANF amount to be used for the Food Stamp Program is $291.

   The agency must evaluate acts of noncompliance with work program requirements where individuals or households must be sanctioned and apply the provisions of Part VIII.A.4 before applying the provisions of this chapter.

2. Social Security (OASDI) benefits, unemployment compensation and veteran's benefits are not means-tested programs. If reduced payments occur for these programs because of a failure to comply, the food stamp allotment will be based only on the current amount of the check(s).

3. HUD payments and SSI are publicly funded and means-tested programs. If reduced payments occur for these programs because of a failure to comply however, the food stamp allotment will be based only on the current amount of the check(s), to the extent the payment is counted as income for food stamp purposes.

E. DISQUALIFIED INDIVIDUALS: TREATMENT OF INCOME, RESOURCES AND DEDUCTIONS (7 CFR 273.11(c))

Individual household members may be disqualified from participating in the Food Stamp Program for a number of reasons. The reason for the disqualification must be assessed because of the different procedures for calculating the income to the remaining household members.

This chapter describes the procedures to be used to determine the eligibility and benefit level of the remaining household members.

1. Resources

The resources of the disqualified individual shall continue to count in their entirety to the remaining household members.

2. Income

a. The earned or unearned income of an individual disqualified:

1) for an intentional program violation;

2) because of noncompliance with work registration;

3) as a result of a sanction for FSET, voluntary quit, or work reduction;

4) for fleeing prosecution or imprisonment or one who is violating terms for parole or probation; or

5) as a result of a felony conviction involving controlled substances,

is counted in its entirety to the remaining household members.

b. A pro rata share of the income of:

1) an individual disqualified for failure to obtain or refusal to provide a Social Security number;

2) an ineligible alien;

3) an individual whose U.S. citizenship is in question and for whom no verification has been provided, or

4) an individual who is unable to participate further because of time-limited eligibility through the work requirement (Part XV),

- **the TANF case is closed because there are no eligible children in the home as a result of a child protective services investigation;**

- the TANF case is closed after discovery that the case was approved in error;

- the food stamp case or members have a sanctioned or disqualified status because of noncompliance with Food Stamp Program rules; and,

- the TANF case closed because of the household's failure to renew its eligibility at the end of the certification period.

1. Calculation of Benefits

Households will receive benefits during the transitional period based on the circumstances that existed at the time of the TANF case closure. In instances where the TANF case is connected to the food stamp case, ADAPT will recalculate food stamps to subtract the TANF grant amount from the food stamp calculation for the month of the TANF case closure. In other instances, the EW must recalculate the benefits. The calculations must reflect the removal of the TANF grant amount and the TANF Match payment for child support received. The calculations must not include a substitution of the TANF amount with any new income amount that may have caused the TANF case closure. The EW must leave all other eligibility factors in place, including income, deductions and household composition.

The EW must not reflect any changes in the food stamp allotment during the Transitional Benefits period. As the agency discovers changes or the household reports changes in its circumstances, the EW must act on those changes for food stamps but override any system recalculations of the allotment to reflect the "frozen" amount as calculated above. In instances where household members leave the household and subsequently apply in another food stamp household, the EW must delete the household members who are in another food stamp household and adjust the allotment for the new household size. In other words, during the Transitional Benefits period, except for household composition changes to delete members to prevent duplicate participation, the EW must not adjust benefits to reflect changes.

Households receiving Transitional Benefits will not be entitled to adjusted benefits through a mass change if a mass change occurs during the Transitional Benefits period.

3. Transitional Benefits Procedures

The Transitional Benefits period will be for five calendar months after the effective date of the TANF case closure. The certification period for Transitional Benefits cases will be five months. The EW must adjust the original certification period to lengthen or shorten the period so that the certification period will be five months.

The EW must provide the household with a Notice of Action to notify the household of the revised benefit amount and new certification period. The agency must send the Notice of Expiration before the last month of the new certification period to notify the household to reapply for benefits in order to continue to receive food stamp benefits.

Households that receive Transitional Benefits are not required to report changes in their circumstances for the Food Stamp Program except a change of address. These households are not subject to the Interim Reporting requirements as addressed in Part XIV.

4. Ending Transitional Benefits

- Eligibility for Transitional Benefits will end the month after an application for TANF benefits is filed if the household reapplies for TANF assistance. The EW must provide an adequate notice for the closure. The application will be treated as an application for food stamp benefits unless the household elects not to apply for food stamps.

- Eligibility for Transitional Benefits will also end as soon as administratively possible if a TANF case is reinstated because of the household's request for continued benefits for a timely-filed appeal. The food stamp case must be changed to reflect the original certification period and calculations that existed before the conversion to Transitional Benefits. The EW must provide an adequate notice.

- Transitional Benefits will end as soon as administratively possible when the household requests closure of the case. The EW does not need to send a notice to the household if the request is made in writing or in person. The household must reapply for food stamp benefits to receive additional benefits.

- Transitional Benefits will end when a household moves from Virginia. The EW does not have to provide either an advance or an adequate notice.

A. CHANGES DURING THE CERTIFICATION PERIOD

When changes occur within the certification period that affect the household's eligibility or the amount of the benefit allotment, the agency must act to adjust the household's benefit level. The responsibility for changes lies with both the recipient household and the local agency. The household must report certain changes in income and household status; the local agency must act to make adjustments in entitlement and benefit level based on reported changes and for changes the agency initiates. Unless prohibited, certified households must file an Interim Report about their circumstances during the certification period.

1. Changes that Must Be Reported

Certified households must report the following changes in their circumstances:

a. A new physical or mailing address.

b. When the total income exceeds the gross income limit based on household size at the time of certification, the Interim Report evaluation, or a change reported during the certification period. The income limits are:

Household Size	Income Limits			
	Monthly Amount	Weekly Amount	Bi-Weekly Amount	Semi-monthly Amount
1	$1,009	$234.65	$ 469.30	$ 504.50
2	1,354	314.88	629.77	677.00
3	1,698	394.88	789.77	849.00
4	2,043	475.11	950.23	1,021.50
5	2,387	555.11	1,110.23	1,193.50
6	2,732	635.35	1,270.70	1,366.00
7	3,076	715.35	1,430.70	1,538.00
8	3,421	795.58	1,591.16	1,710.50
Additional members	+ $345	+ $80.23	+ $160.46	+ $172.50

c. Persons exempt from time-limited benefits of the Work Requirement because they are working for an average of 20 hours per week must report when their work hours fall below 20 hours weekly.

Households that receive benefits through the Transitional Benefits component for former TANF recipients do not have to report changes except changes in their address.

Households must report the changes listed above within 10 calendar days from the date the household knows of the change or, at the

latest, 10 days into the next month after the month the change occurs. The 10-day reporting period will begin the day the household knows of the change. If the household is uncertain of the exact date or amount of the change, then the 10-day reporting period will begin the day the change occurs.

The household may report a change on the Change Report Form, by telephone, by personal contact, by mail, or electronically. The household may also report a change of its circumstances with the filing of the Interim Report. A household member, an authorized representative, or any person having knowledge of the household's circumstances may report the change to any staff member of the local agency. When the household reports the change by mail, the report will be timely as long as the postmark of the letter is within the required 10-day period regardless of when the local agency receives the information.

During the interview, the EW must advise an applicant of the responsibility to report changes within the required period and of the changes the household must report. The EW must provide the household the telephone number of the food stamp office and, if necessary, a toll-free number or a number for accepting collect calls from households outside the local calling area.

The local agency must provide the Change Report Form to each household at initial application and reapplication **and when the agency alters the household size**. Additionally, the local agency must provide the form at recertification, if the household needs another form, and whenever the household returns a form or reports a change in the number of household members. The EW must discuss use of the form with the household during the interview.

An applying household must report changes related to its Food Stamp eligibility and benefits at the certification interview. The household must report the changes noted at the beginning of this chapter that occur after the interview but before the date of the Notice of Action to approve the case within 10 days of the date of the approval notice.

2. Local Agency Action on Changes (7 CFR 273.12(c), 273.2(f))

Except when households receive Transitional Benefits for former TANF recipients, the agency must act promptly to terminate or to adjust benefits when changes in household circumstances are reported by recipient households, including information about an impending change reported at application/renewal. For Transitional Benefits cases, the EW must input changed information in ADAPT during the Transitional Benefits period but grant benefits in the frozen amount calculated when the TANF case closed by using the override feature of ADAPT. (See Part XII.H.)

Localities Whose Residents Are Exempted from the Work Requirement*

July 2001-April 2003	**May 2003-June 2004**	**July 2004-June 2005**	**July 2005-June 2006**
Accomack	Appomattox	Appomattox	Amelia
Buchanan	Bland	Buchanan	Amherst
Carroll	Buchanan	Carroll	Appomattox
Danville	Carroll	Danville	Bedford
Dickenson	Danville	Dickenson	Bland
Giles	Dickenson	Galax	Bristol
Grayson (3/02)	Galax	Giles	Brunswick
Halifax	Giles	Grayson	Buchanan
Henry/ (3/02) Martinsville	Grayson	Halifax	Buckingham
Lee	Halifax	Henry/ Martinsville	Campbell
Norton	Henry/ Martinsville	Lancaster	Carroll
Russell	Lancaster	Lunenburg	Charles City
Surry	Lunenburg	Mecklenburg	Charlotte
Tazewell	Mecklenburg	Northumberland	Cumberland
Wise	Northumberland	Patrick	Danville
	Norton	Petersburg	Dickenson
	Patrick	Pittsylvania	Dinwiddie
	Petersburg	Pulaski	Franklin Co.
	Pittsylvania	Russell	Galax
	Pulaski	Smyth	Giles
	Russell	Williamsburg	Grayson
	Smyth	Wythe	Greensville/ Emporia
	Surry		Halifax
	Williamsburg		Henry/ Martinsville
	Wise		Hopewell
	Wythe		Lee
			Lunenburg
			Lynchburg
			Mecklenburg
			Norton
			Nottoway
			Page
			Patrick
			Petersburg
			Pittsylvania
			Prince Edward
			Prince George
			Pulaski
			Russell
			Scott
			Smyth
			Surry
			Sussex
			Tazewell
			Washington
			Williamsburg
			Wise
			Wythe

*The agency must track the work requirement for all household members except those persons under 18 or over age 50.

PART XXIV FORMS

PART XXIV FORMS (continued)

Commonwealth of Virginia
Department of Social Services

APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid/Children's Health Insurance/FAMIS
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Cash and Medical Assistance

Individuals who have a disability or who have difficulty with English may Receive extra help to make sure they get assistance or services they are Eligible to receive.

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is correct, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

032-03-824/17 (5/04)

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can apply for Food Stamps by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined.**

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and if your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	$_____
Total cash, money in checking/savings accounts, CDs	$_____
Total rent or mortgage for this month	$_____
Total utility expenses for this month Do no count amounts due for previous months. Count only the basic telephone service cost.	$_____
Is anyone in your household a migrant or seasonal farm worker	YES ( ) NO ( )

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

AGENCY USE ONLY

CASE NAME		
CASE NUMBER		
LOCALITY	WORKER	DATE

EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less — YES ( ) NO ( )

Income plus resources less than shelter bills — YES ( ) NO ( )

For migrants or seasonal farm workers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. — YES ( ) NO ( )

EXPEDITE IF YES TO ANY OF THE ABOVE.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decided not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

VIRGINIA SOCIAL SERVICES BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this Application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

YOUR FOOD STAMP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR BENEFITS

AGENCY USE ONLY				
CASE NAME	CASE NUMBER	PROGRAM	WORKER CASELOAD	DATE REC'D.
DATE OF SERVICE REFERRAL	DATE OF INTERVIEW	LOCALITY		

1. I am requesting: ( ) Food Stamps ( ) TANF ( ) Medicaid/Children's Health Insurance/FAMIS ( ) Other Financial or Medical Assistance
( ) I understand that an application for TANF is also an application for Food Stamps and I do not wish to apply for Food Stamps.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		

LANGUAGE (Enter Code) _____

1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C. - Arabic
F - French G - German J - Japanese O - Other

YES ( ) NO ( ) A. Does anyone have an emergency medical need? If **YES**, give name and explain_____

YES ( ) NO ( ) B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____ City\County and State Applicant lived before entering _____
If outside Virginia, was placement made by a government agency? **YES ( ) NO ( )**

YES ( ) NO ( ) C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home?
If **YES**, Spouse's Name _____ Spouse's Address_____

2. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	TYPE OF BENEFITS RECEIVED
WHEN	FROM WHAT COUNTY OR CITY OR STATE	

3. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, Food Stamps, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction_____

4. **YES ( ) NO ( )** Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
If **YES**, explain_____

5. **YES ( ) NO ( )** Have you or anyone for whom you are applying been convicted of a felony for actions that occurred after August 22, 1996, for possession, use or distribution of drugs? If **YES**, explain_____

6. **YES ( ) NO ( )** Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If **YES**, explain_____

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.

2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION.** Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.

3. Answer the questions in **SECTION B: RESOURCES,** unless you are applying for TANF or Children's Health Insurance /FAMIS, for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid** also provide resource information for the following persons:

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Parents who live with a child under age 21.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid or Children's Health Insurance or FAMIS** also provide income information for the following persons:

   TANF: Children age 18 or under, even if you are not applying for that child.
   Stepparent of the children for whom you are applying.

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

   Children's Health Insurance/FAMIS Parents and stepparents who live with a child under age 21.

5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

Food Stamps	**Section D** pp. 8-9
TANF/Medicaid	**Section E** p. 10
Refugee Cash and Medical Assistance	**Section E** p. 10 **only** for children age 18 and under
Children's Health Insurance/FAMIS	**Section F** p. 11
Medicaid/Auxiliary Grants/General Relief	**Section G** p. 11
General Relief	**Section E** p. 10 **only** for children under age 18 **Sections I & J** p. 12
State and Local Hospitalization	**Section H** p. 12
Emergency Assistance	**Section J.** p. 12
Auxiliary Grants	**Section K** p. 12

6. Read **YOUR RESPONSIBILITIES** on page 13.

7. Read and complete **VOTER REGISTRATION** on page 13 of this application.

8. Read and complete the last page of this application. Be sure to sign and date the application.

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME **LIST EVERYONE LIVING IN YOUR HOME**, even if you are not applying for assistance for that person. **LIST YOURSELF ON LINE #1.** Check (√) **YES ( ) NO ( )** Do you expect any change in who lives in your home, either this month or next month? If YES, explain: _____ _____ _____ LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)	2. TEMPORARILY AWAY FROM HOME Is this person temporarily away from home? Check (√) **YES** or **NO** **If YES**, give the date the person left and expected return date If more than 60 days, give the reason for the absence.	3. RELATIONSHIP TO PERSON ON LINE #1 Give the relationship of each person to the person listed on Line #1.	4. TYPE OF ASSISTANCE REQUESTED (Check (√) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person.										
			FOOD STAMPS	TANF	MEDICAID/CHILDREN'S HEALTH INSURANCE/FAMIS	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	AUXILIARY GRANTS	REFUGEE CASH ASSISTANCE	REFUGEE MEDICAL ASSISTANCE	NONE
1 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
2 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
3 ID#	YES ( ) NO ( ) Date Left_____ Expected =Return Date_____ Reason											
4 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
1 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
6 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reaon											
7 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											
8 ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason											

Determine reason person is away.

Determine if any parents or spouses live in the home,
Determine if person under 18 are under parental control,
Determine if anyone is a payee for anyone else

Determine living arrangement, such as subsidized housing for elderly, hospital, incarceration, etc.

If person is in ALF nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or dependent relative is in the home.

Determine living arrangement of the minor parent.

USE THE FOLDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN Check (√) YES or NO If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request	6. ANSWER ONLY IF AN ALIEN Give the **Alien Number** and **Date of Entry** for anyone for whom you are requesting assistance. You may leave this blank for anyone not in the assistance request.	7. PLACE OF BIRTH Give the **State** if born in the U.S. or the **Country** if born outside of the U.S. 8. DATE OF BIRTH	9a. RACE (not required) Give the **code from the list at the bottom of the page** to show Race.	9b. ETHNICITY (not required) Give the **code** to show ethnicity. 1 - Hispanic or Latino 2 - Not Hispanic or Latino	10. SEX Give the **code** to show Sex. M - Male F - Female	11. SOCIAL SECURITY NUMBER Give the number for anyone for whom you are requesting assistance.	12. MARITAL STATUS Give the **code** to show Marital status. 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	13. VETERAN OR DEPENDENT OF A VETERAN Check (√) YES or NO
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )

Race Code List: 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American India/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources.
For Asylees, verify date asylum was granted.
For Veterans, make referral to V.A.
For Medical Expenses, determine retroactive Medicaid entitlement.

Page 3

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH. Check (√) **YES or NO** If **YES**, give the **Date of the Expense**.	**15. EDUCATION** Give the **Last Grade Completed** in school. Check (√) **YES or NO** Is the person a High School (HS) or GED graduate? Check (√) **YES or NO** Is the person **Currently Enrolled** in school? If **YES**, give the **school name** and use one of the **codes** to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	SCHOOL NAME	ENROLLMENT CODE	**16. DISABILITY/ PREGNANT STATUS** Give the **code** to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabld person PG - Pregnant	**17. ANSWER ONLY IF DISABLED** A. Check (√) if the disability reduces or prevents the ability to work or to obtain work. B. Check (√) if the disability reduces or prevents the ability to care for a child in the home. C. Check (√) if the disability requires someone to be in the home to provide care.	**18. ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID** Give the **Conception** month and year and the **Expected Delivery Date**, and the number of **Unborn Children**.
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduat** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduat** **C. ( ) YES ( ) NO Currently Enrolled e**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**

B. RESOURCES

Do not complete this section if you are applying only for TANF, Children's Health Insurance, FAMIS, or Medicaid for parents of dependent children. For all other programs, answer the resource questions for everyone for whom you are applying. If applying for Medicaid for aged, blind, or disabled adults or medically needy children, also provide resource information for the additional persons indicated on the INSTRUCTIONS page. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If **YES**, list owner(s)_____ Amount_____

YES ( ) NO ( ) 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If **Yes** to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (√) **YES ( ) NO ( )** If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid _____.If the savings or investment account is for another purpose, explain _____

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, or deeds of trust?

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 4. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps?
In the last 2 years, if applying for **General Relief**? Any resources or income in the last 5 years if applying for **Medicaid**?

PROPERTY TRANSFERRED		VALUE AT TRANSFER $	AMOUNT RECEIVED $	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED	

Answer the questions below this point (5-12B) only if this is an application for Medicaid, General Relief, Emergency Assistance, State and Local Hospitalization, Auxiliary Grants, or Refugee Medical Assistance.

YES ( ) NO ( ) 5. Burial plots, burial arrangement or trust funds for burial?

OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED
OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 6. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property necessary to your business or trade, including farming?	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 7. Real property, including life estates, land, buildings, or mobile homes? If **YES**, do you live there? Check (√) **YES ( ) NO ( )**

OWNER(S)	TYPE (INCLUDE NUMBER OF ACRES)	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 8. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

YES ( ) NO ( ) 9. Health insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED

YES ( ) NO ( ) 10. Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD

YES ( ) NO ( ) 11. Life insurance policies?

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED
OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED

YES ( ) NO ( ) 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If **YES**, explain.
YES ( ) NO ( ) 12B. Does anyone expect a change in resources this month or next month? If **YES**, explain and give date change is expected.

EXPLAIN

C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for **TANF** or **Medicaid**, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for **TANF** and **Medicaid/Children's Health Insurance/FAMIS** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES or NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Wages/salary
YES ( ) NO ( ) Contract income
YES ( ) NO ( ) Commissions, bonuses, tips
YES ( ) NO ( ) Vacation Pay
YES ( ) NO ( ) Earned sick pay
YES ( ) NO ( ) Babysitting/day care
YES ( ) NO ( ) Farming/fishing
YES ( ) NO ( ) Domestic work
YES ( ) NO ( ) Odd jobs
YES ( ) NO ( ) Other self employment
YES ( ) NO ( ) Any other money from working

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME, ADDRESS PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS
				$ PER			$
				$ PER			$
				$ PER			$

2. Does anyone receive any other type of money? Check (√) **YES OR NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Social Security
YES ( ) NO ( ) SSI
YES ( ) NO ( ) VA benefits
YES ( ) NO ( ) Black Lung benefits
YES ( ) NO ( ) Railroad retirement
YES ( ) NO ( ) Other retirement
YES ( ) NO ( ) Child support, alimony
YES ( ) NO ( ) Military Allotment
YES ( ) NO ( ) Unemployment benefits
YES ( ) NO ( ) Worker compensation
YES ( ) NO ( ) Strike benefits
YES ( ) NO ( ) Interest, dividends
YES ( ) NO ( ) Cash gifts or contributions
YES ( ) NO ( ) Public Assistance
YES ( ) NO ( ) Room/board income
YES ( ) NO ( ) Rental Income
YES ( ) NO ( ) Prize winnings
YES ( ) NO ( ) Insurance settlement
YES ( ) NO ( ) Loans
YES ( ) NO ( ) Training allowances including WIA
YES ( ) NO ( ) Inheritance
YES ( ) NO ( ) All food, clothing, utilities, or rent
YES ( ) NO ( ) Any other type of money

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
				$
				$
				$
				$

For Self Employment Income, determine expenses.
For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.
For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.
For Rental Income, determine whether properly is actively self-managed, expenses.
For Earned Income, determine whether earnings include EITC advance payments.
Inquire if SSI has been applied for.

For Food Stamps, investigate voluntary quit/work reduction.
For TANF, determine the day care option.
For Medicaid, determine income of spouse, dependent child, or dependent relative of person in nursing facility, state hospital, or CBC.

YES ( ) NO ( ) 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				$ PER			

YES ( ) NO ( ) 4. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally supply food or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAYMENT EXPECTED
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

				SCHOOL EXPENSES					
NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR-TATION	DEPENDENT CARE	ROM & BOARD	OTHER (specify)
		$	FROM TO	$	$	$	$	$	$
		$	FROM TO	$	$	$	$	$	$

YES ( ) NO ( ) 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If **YES**, explain and give date: _____

YES ( ) NO ( ) 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (√) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		( ) Disabled		$ PER
		( ) Disabled		$ PER

YES ( ) NO ( ) 8. Does anyone pay legally obligated child support to someone not in the household? If **YES,** person paying: _____

Person supported: _____ Amount paid and how often: _____

YES ( ) NO ( ) 9. **ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED:** Does this person have a work related expense?

If **YES,** give amount and explain: _____

D. FOOD STAMPS

1. List the name of the person who is the head of your household: _____.

NOTE: Refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES ( ) NO ( ) 2. Would you like to name an authorized representative who could apply for food stamps for you, access your food stamp account to buy food for you, or receive food stamp correspondence and notices for you? You may have only one representative who can access your benefits.

	NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	CHECK (√) EACH DUTY AUTHORIZED FOR THAT PERSON
1		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps
2		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps

An authorized representative must have written permission to apply for food stamps. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on your Food Stamp application?

If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved? Check (√) **YES ( ) NO ( ) IF YES**, list names:

_____

YES ( ) NO ( ) 4. Is anyone living in your home a roomer or a boarder? If **YES**, list names: _____

YES ( ) NO ( ) 5. Is anyone age 60 or older, **OR** approved to receive Medicaid because of a disability, **OR** receiving any type of disability check?

If **YES**, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment

YES ( ) NO ( ) 6. Does anyone have any shelter expense for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If **YES,** answer question a, b, and c. Then, give the information requested in boxes.

a. **YES ( ) NO ( )** Are any utilities included in your rent? If **Yes**, leave the boxes for those expenses blank.

b. **YES ( ) NO ( )** Are taxes or insurance included in your mortgage payment? If **Yes,** leave those boxes blank.

c. **YES ( ) NO ( )** Do you have an expense for telephone services? If **Yes**, does anyone living in your home but not included on your Food Stamp application help you pay your telephone bill? Check (√) **YES ( )** or **NO ( )**

If **YES**, explain: _____

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	$	$	$	$	$	$	$	$	$	$	$	$
HOW OFTEN												
WHO PAYS BILL												

YES ( ) NO ( ) 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (√) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Utility Expenses ( ) Utility Standard ( )**

If the **Utility Standard** is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (√) **YES ( ) NO ( )** If **YES,** explain: _____

YES ( ) NO ( ) 8. Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If temporarily staying in someone else's home, give the date you moved in: _____

If **YES,** check (√) whether you would like your food stamp benefits determined using your actual shelter expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Shelter Expenses ( ) Homeless Shelter Allowance ( )**

YES ( ) NO ( ) 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES ( ) NO ( )		YES ( ) NO ( )	YES ( ) NO ( )

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN

ANSWER QUESTIONS 4, 5 AND 6 ONLY IF ANSWER TO QUESTION 3 IS **"SEPARATED, LIVING APART"** AND YOU ARE APPLYING FOR MEDICAID.

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED	**2. PARENT'S STATUS** Check if either PARENT is:				**3. REASONS FOR ABSENCE** **(Answer only if the answer to question 2 is "absent" and you are applying for Medicaid.)** **For each ABSENT PARENT, check reason for absence.**									**4. FINANCIAL SUPPORT** Does the ABSENT PARENT regularly provide monthly financial support? Check (√) **YES** or **NO** If **YES**, give amount, and how often received.	**5. PHYSICAL CARE** Does the ABSENT Parent regularly make sure the child eats, sleeps, bathes, dresses properly, and gets proper medical care? Check (√) **YES** or **NO**	**6. GUIDANCE** Does the ABSENT PARENT regularly particpate in the child's activities, attend school conferences, and share in decisions about discipline? Check (√) **YES** or **NO**	**7. IMMUNIZATION** (Answer only if applying **forTANF and the child is not in school.)** Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **YES** or **NO** or **UNKNOWN**
	UNEMPLOYED	DISABLED	DEAD	ABSENT	PATERNITY NOT ESTABLISHED	DIVORCED OR MARRIAGE ANNULLED	INCAPACITATED	DESERTED	SEPARATED LIVING APART	SENTENCED BY COURT TO DO UNPAID WORK	DEPORTED	ARTIFICIAL INSEMINATION	SINGLE PARENT ADOPTION				
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO (	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
CHILD'S NAME																	YES ( ) NO ( ) UNKNOWN ( )
MOTHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	
FATHER														YES ( ) NO ( ) $ PER	YES ( ) NO ( )	YES ( ) NO ( )	

F. CHILDREN'S HEALTH INSURANCE/FAMIS

YES ( ) NO ( ) 1. Did any of the children listed above have health insurance in the past 4 months? If yes, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: _____ Type of insurance: _____

Date ended _____

Reason insurance ended:

( ) The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
( ) The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
( ) Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
( ) Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
( ) Stopped/dropped by someone other than parent or stepparent.
( ) Stopped/dropped Cobra policy
( ) Other _____

YES ( ) NO ( ) 2. Is any member of the family, including a stepparent who lives in the home, employed by a State or Local Government agency? If yes, list name of family member(s) and agency name: _____

YES ( ) NO ( ) 3. Does the employer of any member of the family offer health insurance for family members? If yes, list the names of the children listed on this application who can get insurance through the employer? _____

G. AGED, BLIND OR DISABLED INDIVDUALS

YES ( ) NO ( ) 1. Have you ever applied for Supplemental Security Income (SSI) or social security as a disabled person? If **YES,** date applied: _____
Check one: ( ) No Decision Yet ( ) Application Approved ( ) Application Denied

YES ( ) NO ( ) 2. If your application was denied, did you file an appeal of the denial? If yes, explain the action taken by the Social Security Administration (SSA) on the appeal request? _____

YES ( ) NO ( ) 3. Has it been less than 12 months since your most recent application for social security or SSI disability benefits was denied? If yes, list the medical conditions that you asked SSA to evaluate. _____.

YES ( ) NO ( ) 4. Has your condition changed or worsened since your most recent application for social security or SSI disability benefits was denied. If yes, explain how your condition has changed or worsened. _____

YES ( ) NO ( ) 5. Do you have a new condition that has occurred since your most recent application for social security or SSI disability benefits was denied? If yes, explain the new condition. _____

YES ( ) NO ( ) 6. Did you receive an Auxiliary Grants check that has stopped? If yes, explain when and why the payments stopped. _____
_____

YES ( ) NO ( ) 7. Did you receive a SSI check that has stopped? If yes, explain when and why the payments stopped. _____
_____

H. STATE AND LOCAL HOSPITALIZATION

YES ( ) NO ( ) Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If **YES**, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: DATE DISCHARGED:

If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES ( ) NO ( )

NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED	NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY

I. GENERAL RELIEF

YES ( ) NO ( ) Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pays?

J. GENERAL RELIEF/EMERGENCY ASSISTANCE

YES ( ) NO ( ) Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY

K. AUXILIARY GRANTS

YES ( ) NO ( ) 1. Do you own any household goods or personal effects which are worth more than $500, such as silver, fine china, furs, artworks, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS

YES ( ) NO ( ) 2. Do you owe or did you pay in the month or application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID

YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

CHANGES

You must report the following changes for the Medicaid Program within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs. The following examples of changes may include some that do not have to be reported for every program. If you are not sure whether to report a particular change, please discuss the change with your worker.

1) Change of address and any changes in shelter costs due to the move
2) Change in the persons in the household – person left, person born, etc.
3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
4) Change in work hours from part-time to full-time or full-time to part-time
5) Change in rate of pay per hour/day, etc.
6) Change in the amount of monthly income received other than from a job.
7) Change in resources
8) Change in motor vehicles owned
9) Change in marital status
10) Person in home is no longer disabled
11) Change in dependent care expenses
12) Other changes that may affect eligibility for a program or the amount of assistance

You must report the following changes for the Food Stamp and Temporary Assistance for Needy Families (TANF) Programs within 10 days, but no later than the 10th day of the month after the change occurs.

1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
2) Change in address.
3) An eligible child has left the home.
4) Changes needed for VIEW (TANF work program).
5) Change in work hours for some food stamp recipients.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell EBT cards. You must not use food stamp benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's, EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to $250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information or hides information about identity or residence to get food stamps in more than one locality at the same time could be barred for 10 years.

Anyone court convicted of trading or selling food stamps of $500.00 or more could be barred permanently.

Anyone court convicted of trading food stamps for a controlled substance could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

Anyone court convicted of trading food stamps for firearms, ammunition, or explosives could be barred permanently for the first violation.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, Food Stamps or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felonyfor actions that occurred after August 22, 1996, could be barred permanently.

INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and would you like to register to vote here today. I certify that a voter registration application form was given to me to complete. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote today.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, you right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

Agency Use Only: Face-to-face interview not required. A voter registration form was mailed.

BY MY SIGNATURE BELOW, I DECLARE:

- I understand all othe information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Control, my benefits may be denied until I cooperate.
- I understand that if my application is for Food Stamps, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.
- I understand that Medicaid, FAMIS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies, to assist with application, enrollment, administration, and billing for services provided to my child in schools. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/Children's Health Insurance/FAMIS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.
- I understand that if I am applying for Medicaid/Children's Health Insurance/FAMIS for my children, I can apply for and receive services from the Division of Child Support Enforcement, but failure to apply for the services will not affect my child(ren)'s eligibility. If I am applying for Medicaid, failure to cooperate my cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames10 days; (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/Children's Health Insurance. For FAMIS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted
- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I received the Benefit Programs Booklet **YES ( ) NO ( )** **MEDICAID APPLICANTS**: I received the Medicaid Handbook **YES ( ) NO ( )**

TANF APPLICANTS: The diversionary assistance program was explained to me. **YES ( ) NO ( )**
The family cap provision was explained to me. **YES ( ) NO ( )**

I filled in this application myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		REALATIONSHIP TO APPLICANT

Commonwealth of Virginia
Department of Social Services
ELIGIBILITY REVIEW – PART A

CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED
CASE NAME	CASE NUMBER	PROGRAM(S)	LOCALITY	WORKER	DATE RECEIVED

This is a review to determine if you continue to be eligible for benefits. Please give correct and complete information on both Part A (this form) and Part B (Separate Form).
IF YOU ARE REPORTING A NEW HOUSEHOLD MEMBER, COMPLETE THE INFORMATION ON THE BACK OF THIS PAGE FOR THE NEW MEMBER.

A. HOUSEHOLD INFORMATION

1. Give your name, address and phone number.

NAME	PHONE NUMBER (HOME) (WORK)
ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)	DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)	

2. List yourself on the first line. Then, list everyone else living in your home, **even if you are not applying for that person**. Include people temporarily away and check the "AWAY" block for them. Give the information requested for each person.

NAME (IF AWAY, CHECK AWAY BLOCK)		PROGRAM(S) REQUESTED						You may leave this blank for anyone not in the assistance request.			CHECK (√) IF IN SCHOOL?		
LAST, FIRST, MIDDLE INITIAL (MAIDEN)	AWAY	FOOD STAMPS	TANF	MEDICAID	IF OTHER, SPECIFY	NONE	RELATION-SHIP TO YOU	SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	YES	NO	IF IN SCHOOL NAME OF SCHOOL

If you answer "YES" to any of the following questions, please explain below.

YES ( ) NO ( ) 3. Is anyone in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
YES ( ) NO ( ) 4. Has anyone been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs?
YES ( ) NO ( ) 5. Is anyone now blind, totally incapacitated, too ill or injured to work, pregnant, or needed to care for an incapacitated person?
YES ( ) NO ( ) 6. Have any of your children received any immunizations since approval of your original application or since your most recent review?
YES ( ) NO ( ) 7. Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your address or identity to receive TANF (AFDC), Food Stamps, or Medicaid in two or more areas at the same time?

If YES, explain: _____

_____

8. **NEW HOUSEHOLD MEMBER INFORMATION** – Give the following information for any new household member you are reporting for the first time. For **TANF and FOOD STAMPS**, also give this information for any new member you have verbally reported since your original application or since your most recent eligibility review.

NAME LAST NAME, FIRST, MI (MAIDEN)	PROGRAM(S) REQUESTED	RELATION-SHIP TO YOU	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	** RACE	** HISPANIC YES	HISPANIC NO	SEX	MARITAL STATUS	CITIZEN-SHIP*	ALIEN REGISTRATION NUMBER*	LAST GRADE	CHECK (√) IF IN SCHOOL YES	SCHOOL NO	CHECK (√) IF A VETERAN YES	VETERAN NO

* **-You may leave this blank for anyone not in the assistance request.**
** **- Not required.**

YES ( ) NO ( ) 9. Is anyone listed above blind, totally incapacitated, too ill or injured to work, pregnant, or needed to care for an incapacitated person? If YES, explain: _____

YES ( ) NO ( ) 10. Is anyone listed above in violation of parole or probation, or fleeing capture to avoid prosecution or punishment of a felony? If Yes, explain: _____

YES ( ) NO ( ) 11. Has anyone listed above been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs? If YES, explain: _____

YES ( ) NO ( ) 12. Has anyone listed above ever been convicted of making false or misleading statements about your address or identity to receive TANF (AFDC), Food Stamps, or Medicaid in two or more areas at the same time? If YES, give date and place of conviction: _____

YES ( ) NO ( ) 13. **(DOES NOT APPLY TO FOOD STAMPS OR TANF)**: Does anyone listed above have any unpaid medical expenses during the last 3 months?

YES ( ) NO ( ) 14. **(DOES NOT APPLY TO FOOD STAMPS)**: If applying for children, list the name(s) and address(es) of any absent parent(s): _____

YES ( ) NO ( ) 15. **(DOES NOT APPLY TO FOOD STAMPS OR TANF)**: If the parents are separated and living apart, does the absent parent(s) provide financial support, physical care, or guidance? If YES, explain: _____

ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT: As long as you are covered by Medicaid or State/Local Hospitalization (SLH), you are required to assign all of your rights to medical support to the Department of Medical Assistance Services (DMAS) and give to DMAS any payment for medical services you receive from another insurer. You are also required to assign these same rights for everyone else for whom you have the legal right to do so. Failure to assign your rights will make you ineligible for Medicaid or SLH. Failure to assign the rights of anyone else will not make that person ineligible for Medicaid. If you are unwilling to assign the rights of a new household member(s), initial the block below and list the name(s) of the person(s) whose rights you do not wish to assign. Otherwise, your signature indicates you agree to assign the rights of the new household member(s).

☐ I refuse to assign the rights of _____

_____ _____ _____ _____
Your Signature or Authorized Representative's Signature or Mark Date Witness for Mark Date

By my signature below, I declare that the household member(s) for whom I am requesting Food Stamps, TANF, Medicaid (unless I am applying for emergency medical services only), is/are either a U.S. citizen(s) or alien(s) in lawful immigration status, and I declare under penalty of law that all information on this form is correct and complete to the best of my knowledge and belief. The Virginia Department of Social Service is an equal opportunity provider. I understand that if there is a food stamp claim against my household, the information on this application, including all SSNs, may be referred to federal and state agencies as well as private claims collection agencies for claims collection action.

_____ _____ _____ _____
Your Signature or Authorized Representative's Signature or Mark Date Witness for Mark Date

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

ADVANCE NOTICE OF PROPOSED ACTION

CASE NUMBER	PROGRAM

DATE OF MAILING:

IF YOU WANT FREE LEGAL ADVICE, CALL: _____
THIS NUMBER IS A LOCAL LEGAL SERVICES AGENCY, NOT THE DEPARTMENT OF SOCIAL SERVICES.

ACTION TO BE TAKEN ON YOUR CASE IS EXPLAINED BELOW.

☐ **FOOD STAMPS** YOUR FOOD STAMP ALLOTMENT WILL BE: ☐ REDUCED ☐ SUSPENDED ☐ TERMINATED

EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:

REASON FOR PROPOSED ACTION: _____

☐ **FINANCIAL ASSISTANCE** YOUR ASSISTANCE CHECK WILL BE: ☐ REDUCED ☐ SUSPENDED ☐ TERMINATED

EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:

MANUAL REFERENCE: _____ REASON FOR PROPOSED ACTION: _____

☐ VIEW TERMINATION - THE TANF CASE IS CLOSED UNTIL YOU REAPPLY AND ARE FOUND ELIGIBLE FOR TANF/TANF-UP
☐ VIEW SANCTION - YOUR HOUSEHOLD'S ENTIRE TANF OR TANF-UP BENEFITS WILL BE SUSPENDED FOR THE ABOVE REASON.
☐ 1ST SANCTION - 1 MONTH OR COMPLIANCE ☐ 2ND SANCTION - 3 MONTHS AND COMPLIANCE ☐ 3RD SANCTION - 6 MONTHS AND COMPLIANCE
YOU HAVE 10 DAYS AFTER THE DATE OF THIS NOTICE TO CONTACT YOUR VIEW WORKER TO SHOW DOCUMENTED GOOD CAUSE.

VIEW WORKER'S NAME _____ TELEPHONE: _____

☐ WHILE YOUR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PAYMENT IS SUSPENDED, ANY SUPPORT PAID TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT FOR YOU OR YOUR DEPENDENTS WILL BE KEPT BY THE STATE TO REPAY THE PAST TANF ASSISTANCE RECEIVED BY YOUR FAMILY. IF YOUR TANF DEBT HAS BEEN FULLY REPAID, YOU WILL RECEIVE THE SUPPORT COLLECTED.

☐ IF THERE IS SOMEONE WHO IS SUPPOSED TO PAY SUPPORT FOR YOU OR YOUR DEPENDENTS, YOU WILL CONTINUE TO RECEIVE SUPPORT ENFORCEMENT SERVICES UNLESS YOU SEND WRITTEN NOTICE THAT YOU DO NOT WANT THIS SERVICE TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT. YOU CAN OBTAIN THEIR ADDRESS AND TELEPHONE NUMBER FROM YOUR LOCAL SOCIAL SERVICES AGENCY.

☐ **MEDICAID, FAMIS PLUS OR STATE/LOCAL HOSPITALIZATION (SLH)**

☐ NO LONGER ELIGIBLE FOR FULL MEDICAID. APPROVED FOR LIMITED MEDICAID COVERAGE:
QMB _____ SLMB _____ QI1 _____
☐ NO LONGER ELIGIBLE FOR MEDICAID. ☐ NO LONGER ELIGIBLE FOR FAMIS PLUS. ☐ NO LONGER ELIGIBLE FOR SLH.
☐ NO LONGER ELIGIBLE FOR PAYMENT OF LONG-TERM CARE BECAUSE OF TRANSFER OF ASSETS.

EFFECTIVE DATE	MANUAL REFERENCE:	ELIGIBILITY WORKER:	TELEPHONE:

INELIGIBLE FAMILY MEMBERS:

REASON FOR PROPOSED ACTION:
☐ INCOME EXCEEDS THE FULL MEDICAID LIMIT. IF MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____ OR MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____, BRING YOUR BILLS TO THIS AGENCY AND YOUR ELIGIBILITY WILL BE REVIEWED.
☐ OTHER: _____

IF YOU DISAGREE WITH THE PROPOSED ACTION, YOU MAY WRITE OR CALL YOUR WORKER AND ASK FOR A CONFERENCE, OR YOU MAY REQUEST IN WRITING A FAIR HEARING TO APPEAL THE ACTION. FOOD STAMP AND TANF ACTIONS MAY ALSO BE APPEALED ORALLY. AT THE HEARING, YOU WILL HAVE A CHANCE TO EXPLAIN WHY YOU THINK WE MADE A MISTAKE AND A HEARINGS OFFICER OR APPROPRIATE AUTHORITY WILL DECIDE IF YOU ARE RIGHT.

IF YOU APPEAL THE PROPOSED ACTION ON YOUR GENERAL RELIEF, AUXILIARY GRANT, OR FOOD STAMP CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF YOU APPEAL THE PROPOSED ACTION ON YOUR TANF, REFUGEE ASSISTANCE, MEDICAID, FAMIS PLUS OR SLH CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF THE HEARING DECISION SUPPORTS THE ACTION BEING PROPOSED BY THE AGENCY, YOU MAY HAVE TO REPAY ASSISTANCE YOU RECEIVED DURING THE APPEAL PROCESS. YOU MAY WAIVE YOUR RIGHT TO CONTINUED ASSISTANCE BY SUBMITTING A WRITTEN STATEMENT TO YOUR ELIGIBILITY WORKER INDICATING YOUR DESIRE TO REFUSE SUCH ASSISTANCE. AN APPEAL CAN BE FILED FOR GENERAL RELIEF AND AUXILIARY GRANT CASES FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE AND FOR FOOD STAMPS FOR UP TO 90 DAYS. FOR TANF, REFUGEE ASSISTANCE, MEDICAID, FAMIS PLUS OR SLH, AN APPEAL CAN BE FILED FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE IF THE PROPOSED ACTION IS EFFECTIVE WITHIN THE NEXT 30 DAYS. IF THE PROPOSED ACTION IS EFFECTIVE MORE THAN 30 DAYS FOLLOWING RECEIPT OF THIS NOTICE, AN APPEAL MAY BE FILED UNTIL THE EFFECTIVE DATE.

NOTE: FOR ADDITIONAL INFORMATION ABOUT APPEALS AND FAIR HEARINGS, REFER TO THE BACK OF THIS FORM.

032-03-018/27 (6-04)

APPEALS AND FAIR HEARINGS

SEND WRITTEN APPEALS TO THE ADDRESSES BELOW. YOU MAY ALSO FILE A FOOD STAMP OR TANF APPEAL ORALLY BY CALLING YOUR LOCAL AGENCY OR DIALING TOLL FREE 1-800-552-3431.

FINANCIAL ASSISTANCE AND FOOD STAMP APPEALS SHOULD BE SENT TO:

HEARINGS AND LEGAL SERVICES MANAGER
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
7 NORTH EIGHTH STREET
RICHMOND, VA 23219-3301

MEDICAID, FAMIS PLUS, AND SLH APPEALS SHOULD BE SENT TO:

CLIENT APPEAL DIVISION
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for financial assistance, Medicaid, FAMIS Plus, SLH, and/or food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearings officer is the official representative of the State Department of Social Services or the Department of Medical Assistance Services.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to say why you disagree with the agency's proposed action. At the conference, you have the right to have your story presented by an authorized representative, such as a friend, relative or lawyer.

If you request the conference within 10 days of receipt of your Advance Notice of Proposed Action to decrease, suspend or terminate your services, financial assistance or food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your financial assistance be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. You must request the appeal within 10 days of the conference date for Food Stamps. If you do not request a conference but file your appeal within 10 days of your advance notice of action to reduce, suspend, or terminate your services, financial assistance or food stamps, your benefits may be continued until a hearing decision is reached. If you appeal the proposed action on your TANF, Refugee Assistance, Medicaid or FAMIS Plus case prior to the reduction, suspension, or termination effective date, you may also receive continued assistance. However, if the agency action is upheld, you will be required to repay assistance received during the appeal process.

If you request an appeal concerning food stamps, the local social services agency must offer you a conference after your appeal is filed.

The person who conducts the hearing is someone from the State Department of Social Services or the Department of Medical Assistance Services, not someone from your local social services agency. The hearings officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) Examine all documents and records that are used at the hearing;

(2) Present your case or have it presented by a lawyer or by another authorized representative;

(3) Bring witnesses;

(4) Establish pertinent facts and advance arguments; and

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearings officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services. If the decision is based on a Medicaid, FAMIS Plus or SLH appeal, you will be notified in writing within 90 days of the date your appeal is received by the Department of Medical Assistance Services.

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

GENERAL INFORMATION

This Request for Assistance is the first part of the application process and protects your application date. You must also complete the second part of the application process by (1) having an interview, or (2) completing an Application for Benefits form, or another appropriate Medicaid application.

With this Request for Assistance, you can begin the application process for one or more of the following assistance programs. You can also use this Request to request a Medicaid resource assessment for long term care.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid Children's Health Insurance
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Refugee Cash Assistance
- Refugee Medical Assistance

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required, but if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help some else receive benefits, you could be arrested and prosecuted for fraud. You must also provide required verifications.

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can begin the application process for Food Stamps by completing this Request for Assistance or by completing only the information in the boxes below and providing at least your **name, address, and signature.** You must complete the rest of the application process before your eligibility can be determined.

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in this Request for Assistance before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your Request.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farmworker household with little or no income and resources. **GIVE THE INFORMATION REQUESTED IN THE BOXES BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	$_____
Total cash, money in checking/savings accounts, CDs	$_____
Total rent or mortgage for this month	$_____
Total utility expenses for this month	$_____
Do no count amounts due for previous months. Count only the basic telephone service cost.	
Is anyone in your household a migrant or seasonal farmworker	YES ( ) NO ( )

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it incorrect, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBLITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the U.S. Citizenship and Immigration Services (USCIS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

VIRGINIA SOCIAL SERVICES – BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE REQUEST FOR ASSISTANCE

If you need help completing this Request for Assistance, a friend or relative or your eligibility worker can help you. If you are completing this Request for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 6 people are living in your home and you need more space to list everyone, tell the agency you need extra pages.

FILING A REQUEST FOR ASSISTANCE

You may turn in a partially completed Request for Assistance which contains at least your **name, address, and signature** (or the signature of your authorized representative), but you must complete the rest of the application process before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Request for Assistance before your interview.

You may return your Request for Assistance by mail, fax, or in person. If you return the form in person, you may turn it in any time during office hours the same day you contact your local social services agency. You have the right to file your Request for Assistance, even it looks like you may not be eligible for benefits.

Your Food Stamps Rights

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD), USDA is an equal opportunity provider and employer.

AGENCY USE ONLY
EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less — **YES ( ) NO ( )**

Income plus resources less than shelter bills — **YES ( ) NO ( )**

For migrants or seasonal farmworkers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. — **YES ( ) NO ( )**

EXPEDITE IF YES TO ANY OF THE ABOVE

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

AGENCY USE ONLY			
CASE NAME	CASE NUMBER(S)	PROGRAM(S)	REGISTRATION NUMBER
APPLICATION TYPE	LOCALITY	WORKER	CASELOAD NUMBER
DATE OF SERVICE REFERRAL		DATE RECEIVED	

1.

APPLICANT'S NAME	C/O NAME	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP)	MAILING ADDRESS (IF DIFFERENT)	DIRECTIONS TO HOME

2. Check ( ) your household's primary language: ( ) English ( ) Spanish ( ) Cambodian ( ) Vietnamese ( ) Other_____
( ) Kurdish ( ) Arabic ( ) Japanese ( ) German ( ) French ( ) Farsi
( ) Somali ( ) Haitian-Creole ( ) Laotian ( ) Chinese ( ) Korean

3. LIST EVERYONE LIVING IN YOUR HOME, even if you are not requesting assistance for that person. List yourself on the first line. If you are married, list your spouse on the second line. Then list everyone else. Provide the information requested for each person listed. Check (□) type of assistance requested for each person. If no assistance is requested, check NONE for that person. A Social Security Number and an Alien Registration Number do not have to be provided for any individual for whom assistance is not being requested.

NAME FIRST MI LAST SUFFIX (JR., SR.)	SEX M,F	RACE SEE* BELOW	ETHNICITY SEE** BELOW	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ALIEN REGISTRATION NUMBER	Food Stamp	TANF	MEDICAID CHILDREN'S HEALTH INSURANCE	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	REFUGEE MEDICAL ASSISTANCE	REFUGEE CASH ASSITANCE	MEDICAID RESOURCE ASSESSMENT	NONE	THIS PERSON'S RELATIONSHIP TO YOU	AGENCY USE ONLY CLIENT ID
(Your Name)																		
(Your Spouse's Name, if you are married)																		

* RACE: (Not required) Use these codes to indicate RACE: 1 – White, 2 – Black or African American, 3 – American Indian or Alaska Native, 4 – Asian, 5 – Native Hawaiian or Pacific Islander. 6 – American Indian or Alaska Native and White, 7 – Asian and White, 8 – Black or African American and White, 9 – American Indian or Alaska Native and Black or African American, A – Asian and Black, B - Other

** ETHNICITY: (Not required) Use these codes to indicate ETHNICITY: 1 – Hispanic or Latino, 2 – Not Hispanic or Latino

4. List anyone from #3 above who is pregnant_____
or who is disabled:_____

5. List anyone from #3 above who is requesting Medicaid who had medical treatment during the 3 months before this request:_____

6. YES ( ) NO ( ) Have you or anyone for whom you are applying ever applied for or received or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid Children's Health Insurance, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, Refugee Cash or Medical Assistance?

Person Who Applied for or Received Benefits	Under What Case Name	Type of Benefits Received
When	From What County or City of State	

7. YES ( ) NO ( ) Does anyone have any of the following emergencies? If **YES,** check (✓) the type of emergency and explain the cause.
( ) Food ( ) Shelter ( ) Medical ( ) Clothing ( ) Other Emergency_____
Cause: _____

8. YES ( ) NO ( ) Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, child care needs, family planning, family violence, referrals to other community organizations, or other problems or concerns. If **YES**, explain.

Explain:

BY MY SIGNATURE BELOW I DECLARE, UNDER PENALTY OF PERJURY, THAT ALL OF THE FOLLOWING ARE TRUE:
I understand:

- All of the information in the GENERAL INFORMATION Section on pages 1 and 2.
- If I give false, incorrect, or incomplete information, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone else complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.

I received the Benefit Programs Booklet **YES ( ) NO ( )** **MEDICAID APPLICANTS:** I received the Virginia Medicaid Handbook **YES ( ) NO ( )**

All information I gave on this Request for Assistance is correct and complete to the best of my knowledge and belief. I authorize the release to this agency of all information necessary to determine my eligibility.

I filled in this Request for Assistance myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	WITNESS TO MARK OR INTERPRETER	DATE

COMPLETE THE BOX BELOW IF THIS REQUEST FOR ASSISTANCE WAS COMPLETED FOR THE APPLICANT BY SOMEONE ELSE:

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		RELATIONSHIP TO APPLICANT

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF BENEFIT PROGRAMS

INTERNAL ACTION AND VAULT EBT CARD AUTHORIZATION

TO: _____ Vault Card Issuance Unit _____ EBT Administrative Terminal Personnel Date ____/____/____

FROM Eligibility Worker/Supervisor: _____ Telephone Number:_____

RE: Case Name:_____ Case Number:_____

I. [ ] Authorization for a Vault EBT Card
Vault card reason: (1) ___ Timely processing (2) ___ Household emergency (3) ___ Agency determination

Case Name Social Security Number_____ Case Name Birth Date ____/____/____

[ ] Issue a vault card to Authorized Representative _____

Address of vault card recipient: _____

II. [ ] Authorization for crediting the card replacement fee to the household's account

Reason: ❑ Household disaster: ❑ Lost in the mail ❑ Household Violence
❑ Improperly manufactured ❑ Reapplication, no card ❑ Cardholder name changed

III. [ ] Administrative error – Debit account for $_____

IV. [ ] Reactivate dormant EBT account.

V. [ ] Repay FS Claim of $_____ from ❑ Active ❑ Dormant/expunged account

---

Issuance/Administrative Unit Use

I. EBT Vault Card Number:_____ Card destroyed on _____/_____/_____

Type of identification seen:
❑ Driver's License ❑ Rent/Utility Bill/Receipt ❑ School ID Card ❑ Work ID Card
❑ Library Card ❑ Social Security Card ❑ Other _____

I acknowledge that I received my EBT card or that I received the card on behalf of another household. I understand that I need to select a Personal Identification Number to use my benefits.

_____ _____
Cardholder's Signature Date

[ ] Cardholder failed to pick up vault card. ❑ Card destroyed ❑ Vault card not prepared

II. Replacement fee credited on _____/_____/_____.

III. EBT account debited for $_____ for an administrative error on _____/_____/_____.

IV. EBT account reactivated on _____/_____/_____.

V. Repaid $_____ to FS Claim on _____/_____/_____.

Completed by _____ _____
Issuance/Administrative Worker Date

032-03-387/4 (4/05)

Internal Action and Vault EBT Card Authorization

FORM NUMBER - 032-03-387

PURPOSE OF FORM - The Eligibility Unit will use this form to communicate with the Issuance or Administrative Unit in the local agency.

USE OF FORM - The EW must complete the top portion of the form to authorize the Issuance Unit to prepare and issue a vault card to an eligible household **or authorized representative**. The Eligibility Supervisor must complete the top portion of the form to authorize the Issuance or Administrative Supervisor, as designated by the agency, to credit the card replacement fee to a household's EBT account. The Issuance or Administrative Unit must complete the bottom portion of the form to document the action taken. The primary cardholder **or authorized representative** must also sign the form to acknowledge receipt of the vault card. The agency must use the internal action form to document repayment of a claim with funds in an EBT account or to debit an account for an administrative error.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The Eligibility Worker or Supervisor must retain a copy of the form and forward the remaining copies to the Issuance or Administrative Unit for completion. The Issuance or Administrative Unit must retain a copy of the fully completed form and return the second copy to the Eligibility Unit. Upon receipt of the form, the Eligibility Worker or Supervisor must file the copy in the case file. The initial copy completed only by the Eligibility Unit may be discarded.

INSTRUCTIONS FOR PREPARATION OF FORM - The EW or Supervisor must complete the identifying case and unit information. The EW or Supervisor must complete the appropriate section of the top portion of the form to explain or authorize actions, including Section I to note why a vault card is necessary. **The EW must include the address of the person who will receive the vault card, either the primary cardholder or authorized representative, for entry in the EBT system. The EW may attach a copy of the AECASE or AECAS1 ADAPT screen, as appropriate, to avoid transcription errors.**

The Eligibility Supervisor must complete Section II to authorize crediting the card replacement fee back to the household's EBT account. The Eligibility Supervisor must also complete Section III to debit benefits from an account that were erroneously deposited as a result of an administrative error.

The EW or Supervisor may authorize the reactivation of a dormant account by completing Section IV. The Primary Cardholder may also contact the Issuance or Administrative Worker directly to request the reactivation of the account. The EW or supervisor may also authorize deducting funds from an account to repay a claim by completing Section V.

The Issuance Unit must promptly act to prepare a vault card for a household upon receipt of the form completed by the Eligibility Unit. The Issuance Worker must obtain and record identity verification before releasing the vault card and secure the signature of the **primary** cardholder **or authorized representative** on the form.

The completed form must remain with a prepared vault card until the cardholder comes to the agency. The Issuance Unit must destroy the card after five business days if the cardholder does not receive it or make additional arrangements to receive the card. The Issuance Worker must note the date of the destruction of the card on the form. If the agency opts to wait until the cardholder comes to pick up the vault card before preparing the card, the Issuance Unit must notify the EW if the cardholder fails to obtain the card within five business days after the initial authorization by the certification unit.

The supervisor of the Issuance or Administrative Unit, as determined by the agency, must complete the section to credit the card replacement fee back to the household's EBT account.

The Issuance or Administrative Worker or Supervisor must sign and date the form.

Commonwealth of Virginia
Department of Social Services
REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

<table>
<tr><td>Case Name</td><td>Case Number</td><td>Locality</td></tr>
<tr><td>Member Suspected</td><td colspan="2" rowspan="2">TANF Violation (circle one) 1 2 3

Period of IPV

Amount of Overpayment $</td></tr>
<tr><td rowspan="2">Address (include city, state, zip)</td></tr>
<tr><td colspan="2">Food Stamps Violation (circle one) 1 2 3

Period of IPV

Amount of Overissuance $</td></tr>
</table>

The suspected household member is alleged to have committed the following act(s) of intentional program violation:

We have the following evidence to support our case:

Copies of evidence to be presented at the hearing to prove the allegation are attached, including: 1) Verification or documents to support the charge; 2) Any applications for Temporary Assistance for Needy Families or Food Stamps signed by the accused during the time in which the intentional program violation allegedly occurred.

Information in this referral is provided with the knowledge it will be used in reaching a decision on the allegations made in this referral, and will be made available to the accused individual or representative.

Submitted by	Title	Telephone	Date

032-03-725/3

REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING

FORM NUMBER - 032-03-725 This form and instructions are available online at **www.localagency.dss.state.va.us/divisions/bp/forms.cgi**.

PURPOSE OF FORM - To refer cases to the State Hearing Authority where an individual is suspected of having committed an intentional program violation.

USE OF FORM – The local agency worker must complete the form to provide information needed by the State Hearing Authority in order to initiate an administrative disqualification hearing. Mail the referral to:

Virginia Department of Social Services
Hearings and Legal Services Manager
7 North Eighth Street
Richmond, VA 23219-3301

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The local agency must send the original and one copy to the Hearings Manager and keep a copy.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the information requested at the top of the form. The Period of Intentional Program Violation (IPV) is the span of time over which the IPV occurred. This will often coincide with the dates over which a claim was established.

The "Amount of Overissuance" is the total amount of the claim which relates to the IPV. If the IPV was due to an act which did not result in an overissuance, for example, using food stamps to pay rent, or misrepresenting the household's income on an application that was subsequently denied, indicate "0" overissuance in this block.

Explain the intentional act alleged and the evidence the agency has to support its claim. Evidence listed here is to be made available to the individual and will be presented at the hearing. Confidential or other information restricted from the household cannot be the basis of the evidence to support the accusation of an IPV.

The agency director/superintendent or designee must sign the form.